State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2567
www.caldocinfo.ca.gov

APPLICATION FOR INACTIVE LICENSE *Please print or type.* *Illegible applications will be returned.*	**FOR OFFICE USE ONLY** **Date Received:** _____ **Date Application Approved:** _____ **Enforcement Approval:** ____Yes ____No **Date:** _____

Name (first, middle, last):	
Address: **Is this address on file with the Medical Board as your official address of record? If not, complete reverse.**	
Telephone Number: **FAX Number (if applicable):**	Telephone ( ) FAX ( )
Social Security Number:	
California Medical License Number:	

Section 700 of the Business and Professions Code permits a licensee who is not actively engaged in the practice of medicine in the State of California to maintain licensure in a nonpracticing status. This status is provided with the issuance of an "inactive" license. If your California Physician's and Surgeon's license is currently suspended, revoked, or otherwise restricted by the Board an "inactive" license cannot be issued to you.

To apply for an inactive license complete all areas of the application above. At the time of application, if your physician's and surgeon's license is delinquent, a payment of all renewal fees, the delinquent fee, and penalty fee must be submitted with the application. If your physician's and surgeon's license has not expired, no fee is required at this time. *The fee to renew an "inactive" license is the same fee as that required to renew an "active" license.*

If your application is approved, you will be exempt from complying with the Continuing Medical Education (CME) requirements. However, if you request to return to active licensure you will be required to document compliance with those requirements before an active license can be issued to you.

REMEMBER: If you hold an "inactive" license, you cannot engage in any activity for which an active license is required.

I certify under the penalty of perjury under the laws of the State of California, that the information provided in this application and including any supporting documents is true and correct and that I am licensed to practice in the State of California.

_____ _____
Applicant's Signature **Date**

All items in this application are mandatory; none are voluntary. This information is requested by the Division of Licensing of the Medical Board of California. Failure to provide any of the requested information may result in this application being rejected as incomplete. The information provided will be used to determine your eligibility for an Inactive license, pursuant to Section 701 of the Business and Professions Code. The Licensing Program Chief is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act by contacting the custodian of records at the above address. Information in this application may be transferred to other governmental and law enforcement agencies.

Disclosure of your Social Security number (SSN) or Federal Employer Identification Number (FEIN) is mandatory. Section 30 of the Business and Professions Code and Public Law 94.455 (42 USCA 405(c)(2)(C)) authorize collection of your SSN. Your SSN or FEIN will be used for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or FEIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

BOTH PAGES OF THIS FORM MUST BE COMPLETED

CURRENT MAILING ADDRESS

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❑ **Check here if this is a change of address so that your record can be updated. If this is a post office box, you must list a confidential street address.**

FINANCIAL INTEREST

If you have any financial interest to report, please complete the portion below. If not, state "NO" here (Attach additional sheet(s), if necessary.)

California's Financial Interest Disclosure law (Business and Professions Code Section 2426) requires you to disclose any financial interest that you or your immediate family have in specified health-related facilities located in or outside the State of California. Immediate family means a spouse, child or parent of a licensee, and a spouse of a child of a licensee.

Financial interest includes any type of ownership interest including share or stock ownership, limited partnership interest, debt, loan, lease, compensation, remuneration, general or limited partnership interest, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment of money or anything else of value to a licensee or the licensee's immediate family from a health-related facility.

Health-related facility means any facility that provides clinical laboratory services, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, diagnostic imaging, or outpatient surgery centers. Diagnostic imaging includes all x-ray, computed axial tomography, magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography and ultrasound goods and services.

A financial interest does not include the ownership of corporate investment securities, including shares, bonds, or other debt instruments that (1) are purchased from a licensed securities broker on terms available to the general public through a licensed securities exchange or NASDAQ, (2) do not base any profit distributions or other transfers of value on the licensee's referral of patients, (3) does not have a separate class or accounting for any persons or licensees who may make patient referrals to the corporation, and (4) are in a corporation which has total gross assets exceeding $100,000,000.

Health-Related Facility Name(s)	Facility's Address

I certify under penalty of perjury under the laws of the State of California that I read and understand the information defining financial interest and that I have disclosed on this application the names of those health-related facilities in which I or my family have a financial interest.

Applicant's Signature_____ **Date**_____